EMPLOYEE BENEFITS OVERVIEW 2019

LIVE WELL. WORK WELL.

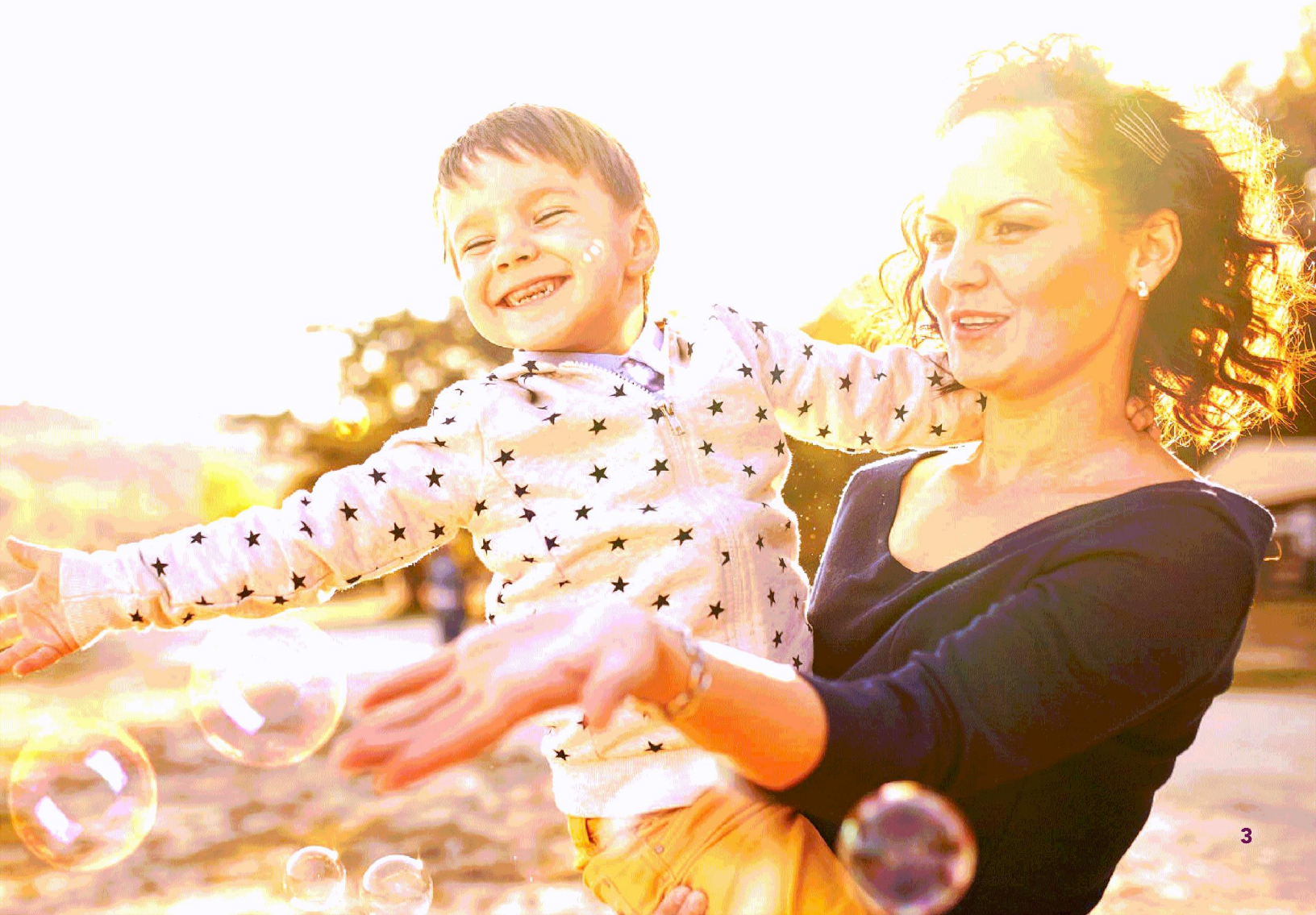
GRAPEVINE TEXAS RISK MANAGEMENT

ACTION REQUIRED

You must reenroll during this Open Enrollment period to maintain current elections.

YOUR CHOICE.
YOUR PLAN.

TABLE OF CONTENTS



KNOW YOUR BENEFITS

EMPLOYEE BENEFITS

Employee benefits are an integral part of our comprehensive compensation program at the City of Grapevine. We are pleased to offer a robust package of benefits and programs for you and your eligible dependents. The coverage you choose during this period will begin October 1, 2018 and remain effective until September 30, 2019.

WHO IS ELIGIBLE

Elected officials, full-time and regular part-time employees regularly scheduled to work at least 20 hours per week are eligible for benefits. Employees are eligible for all benefits on the first of the month following date of hire. Your eligible dependents may also be enrolled for coverage. Eligible dependents include:

- Your legal spouse
- Your dependent children under age 26

QUALIFYING LIFE EVENTS

The benefits you choose at hire or during Open Enrollment must stay in place until September 30, 2019 unless you have a qualifying life event, which includes the following:

- You have a change in marital status
- You have a baby, adopt a child, or have a child placed with you for adoption
- You become disabled
- You or a dependent dies
- You end your employment with the City
- Your spouse gains or loses employment
- Your dependent child gains or loses eligibility due to age

If you experience a qualifying life event and wish to change your benefits, you must complete the change in SmartBen and submit the necessary documentation to Risk Management within 30 days of the status change. If you do not return the necessary paperwork within 30 days, your coverage will remain until the following open enrollment window.

REQUIRED DEPENDENT DOCUMENTATION

Please note that the City of Grapevine requires employees enrolling dependents to submit documentation to substantiate their eligibility. A marriage license is required for a spouse and birth certificates for any child(ren).

SPOUSE SURCHARGE

If your working spouse is eligible to participate in or be covered by another health plan, benefits under this plan will be paid on a secondary basis, prescription benefits are excluded, and an additional premium of $300 per month is assessed (excluding Medicare and Medicaid).

OPT-OUT CREDIT

If you choose to opt-out of the City of Grapevine medical plan, you will receive $500 into a flexible spending account. This money can be used to pay for eligible healthcare expenses not covered by another medical insurance plan.

If you have a qualifying life event and opt back into the plan, unused money will be forfeited. If both you and your spouse are City employees and opt out of the plan, only one benefit will be given. Details on the Flexible Account program are available on page 15.

HOW TO ACCESS SMARTBEN

SMARTBEN – ONLINE BENEFIT ENROLLMENT SYSTEM

SmartBen enables you to explore and understand the range of benefits offered by the City of Grapevine. SmartBen will educate you, help you plan, and enroll in benefits anywhere you have an internet connection.

HOW TO ACCESS SMARTBEN?

www.smartben.com
Username: SSN (no dashes)
Password: Date of Birth (MMDDYYYY – no slashes)

What information is available on SmartBen?

- Current benefit enrollment details
- Beneficiary designations
- Dependent information
- Plans & Policies
- Retirement Planning

When do I use SmartBen?

- New Hire Enrollment
- Open Enrollment
- Life Event Changes
  - Marriage
  - Divorce
  - Birth or adoption of a baby
  - Change in employment status

Did you make a change in SmartBen? Key checkpoints:

- Ensure that you click "Confirm" after you are finished making changes so they are submitted and processed without clicking confirm the changes will not process
- Submit necessary documentation to Risk Management
  - Adding a new baby?
    - Submit a birth certificate
  - Adding a new spouse?
    - Submit a marriage license
  - Dropping a dependent due to an employment change?
    - Submit a letter from their employer verifying the change

WORKPLACE WELLNESS

Viverae has rebranded to **SimplyWell**

The daily demands of life and work can make it hard to live a healthy lifestyle. The City of Grapevine appreciates you and wants to provide the tools and support you need to be healthy and well. We have partnered with SimplyWell, a leading health management services provider, to bring you the latest health and wellness content, educational programs, and an online community to keep you motivated.

Workplace Wellness is a vital part of our overall benefits program. Whether your goal is to have more energy, to lose weight, to manage stress, or to improve your diet, the Workplace Wellness program can help you. The lower premium incentives shown below will apply to the 2019-2020 benefit plan year effective October 1, 2019. Refer to your connect.simplywell portal for current plan year incentives and deadlines.

HOW TO REGISTER

STEP 1

- Visit **connect.simplywell.com**
- Click **New User Registration**
- Enter your last name and date of birth (DOB)
- Enter your identifier: **1st letter of first name + 1st letter of last name + last 4 digits of SSN**
- Enter the registration code: **Grapevine**

STEP 2

- Create a user name (5-25 characters)
- Create a password (8-12 characters) using letters (upper and/or lowercase), numerals and/or special characters (such as @$%&#)
- Select a security question and answer, then click **Save**

PROGRAM ACTIVITY	PARTICIPATION LIMIT	POINT VALUE	COMPLETE BY DATE
Member Health Assessment (MHA)	Annual	50	8.31.19
Biometric Screening Physician lab form deadline is 7/31/19	Annual	50	
Annual Physical Exam	Annual	50	
Self-report tobacco-free or targeted tobacco cessation program passed	Annual	50	
WELLNESS CREDIT ($50/MONTH OR $600/YEAR – MEDICAL PREMIUM DISCOUNT)*		200	

**** If your spouse is enrolled in the medical plan, they must also complete the Wellness Credit goals for the employee premium discount.***

Group Fitness Class (i.e. Employee Fitness) - Attended 1 class	Unlimited	1	8.31.19
Health Talks - Attended	Once per month	5	
Participation in 5k Walk/Run	Once per month	5	
300,000 steps per month	Once per month	5	
Online Course / Webinars	Up to 10	6	
Carter Blood Drive	Up to 3	10	
Flu Shot	Annual	10	
Participation in 10k Walk/Run	Up to 6	10	
Peer Challenges Completed (10 day minimum)	Up to 4	10	
Health Fair	Annual	15	
Complete the City of Grapevine CPR Course	Annual	20	
Employer Challenges - Goals Met	Up to 3	20	
$40 - CASH		100	
$60 - CASH ($100 total)	(Additional)	150	

PREMIUM DISCOUNT PROGRAM

FOUR PARTS TO OBTAINING THE WELLNESS CREDIT
Employee and spouse requirement

1. Member Health Assessment
   - Create a wellness portal and complete your assessment at **connect.simplywell.com**
2. Biometric Screening
   - Check your connect.simplywell portal for available dates and to schedule an on-site screening

   OR
   - Schedule an appointment with your primary care physician, have the physician lab form completed and return back to SimplyWell using the instructions on the form
3. Annual Physical/Preventative Care Compliance
   - Complete an annual physical with your in-network primary care physician
4. Tobacco-Free Affadavit or Targeted Tobacco Cessation
   - Information found at **connect.simplywell.com**

MEDICAL PROVIDER INFORMATION

The Wellness Credit will apply for employees and/or spouses who receive a complete annual physical as evidenced by a CPT code ranging from 99381 through 99429 appearing as one of the codes on the submitted UMR claim. In order to facilitate the completion of the wellness exam incentive requirement, we request that a CPT code ranging from 99381 through 99429 be listed as the primary code when submitting the insurance claim to UMR for payment so long as the annual physical is the primary reason for the visit.

While physicals and wellness exams often include such things as a blood pressure check, cholesterol test, glucose test, and/or a body mass index check no specific tests are required as the City of Grapevine feels the judgment of your physician is best in determining which tests to administer based on the patient's age, gender, medical history and physical condition.

HAVE I SATISFIED THE REQUIREMENTS?

1. Register with SimplyWell at **connect.simplywell.com**
2. Log into the portal to check your status on satisfying the requirements:
   - ALL data will feed over to the connect.simplywell portal, including fire department completed physicals, biometric screenings, and annual physicals filed through UMR
   - Each step of the 2019 premium discount requirement is worth 50 points, you should have a total of 200 points to satisfy both requirements
3. If your data does not appear:
   - Confirm with your provider that the visit was processed through insurance with correct codes
   - Contact the SimplyWell Health Center for more information

WHAT ARE THE DEADLINES?

Please reference the SimplyWell portal for program goals and deadlines also found at connect.simplywell.com

MEDICAL & PRESCRIPTION DRUG PLANS

You may choose from two plans through UMR who participates in the United Healthcare Choice Plus Network.

UMR | 877.360.4503 | umr.com

		TRADITIONAL	PREMIER
		NETWORK	NETWORK
THRESHOLD DEDUCTIBLE	Individual	$1,000	N/A
	Family	$2,000	N/A
		HRA	HSA
CITY CONTRIBUTION	Individual	$750	$1,000 option for add. personal contribution
	Family	$1,500	$2,000 option for add. personal contribution
DEDUCTIBLE	Individual	$1,750 (Co-pays not included)	$2,700
	Family	$3,500 (Co-pays not included)	$4,000
OUT-OF-POCKET MAXIMUM	Individual	$2,750	$3,500
	Family	$5,500	$5,500
OUT-OF-POCKET MAXIMUM (Prescription drugs)	Individual	$3,000	N/A
	Family	$6,000	N/A
OFFICE VISIT	Physician	$25 (No referrals required)	Subject to deductible then coinsurance rates
	Specialist	$25 (No referrals required)	Subject to deductible then coinsurance rates
	Urgent Care	$25 (No referrals required)	Subject to deductible then coinsurance rates
	Emergency Room	$250 co-pay then 80% (co-pay waived if admitted)	Subject to deductible then coinsurance rates
	Preventative	100%	100%
RETAIL (34-day supply)	Generic	$4	$4 (after deductible)
	Preferred Brand	20% min. $15	20% min. $15 (after deductible)
	Nonpreferred Brand	30% min. $30	30% min. $30 (after deductible)
MAIL ORDER (100-day supply)	Generic	$8	$8 (after deductible)
	Preferred Brand	20% min. $30	$30 (after deductible)
	Nonpreferred Brand	30% min. $60	30% min. $60 (after deductible)
SPECIALTY DRUG (30-day supply)	Generic	$4	$4 (after deductible)
	Preferred Brand	20% min. $40	30% min. $40 (after deductible)
	Nonpreferred Brand	40%	40% (after deductible)

	Wellness Credit		Non-Wellness Credit		Wellness Credit		Non-Wellness Credit	
	Monthly	*Bi-Weekly*	*Monthly*	*Bi-Weekly*	*Monthly*	*Bi-Weekly*	*Monthly*	*Bi-Weekly*
Employee Only	$55.82	$25.76	$105.82	$48.84	$0	$0	$72.68	$33.54
Employee and Spouse	$100.48	$46.38	$150.48	$69.45	$40.83	$18.84	$90.83	$41.92
Employee and Child(ren)	$94.90	$43.80	$144.90	$66.88	$38.56	$17.80	$88.56	$40.87
Employee and Family	$150.00	$69.23	$195.14	$90.06	$60.00	$27.69	$108.98	$50.30

Coinsurance coverage is 80%. All out-of-network coverage is excluded.

Employee and spouse must complete requirements to receive the Wellness Credit premium

HSA & HRA ACCOUNTS

HEALTH SAVINGS ACCOUNT (HSA)

When you enroll in the Premier you will create a Health Savings Account with HSA Bank. This medical bank account is in your name and owned by you allowing you to take the account with you regardless of employment status.

Individuals can use this tax-free money to pay for expenses including to assist in satisfying the plan deductible, coinsurance costs after the deductible has been met, and qualified medical expenses not covered by the high deductible health plan; such as, dental and vision.

IRS CONTRIBUTION LIMITS

- *Contributions to the HSA are limited to the amount established by the IRS guidelines.*
- *2018 – $3,450 for employee only and $6,750 for employee and spouse, child or family.*
- *2019 – $3,500 for employee only and $7,000 for employee and spouse, child or family.*
- *Employees are not eligible to use HSA funds on adult children, ages 24-26.*
- *Individuals 55 years of age or older and not enrolled in Medicare are allowed an additional $1,000 annual catch-up contribution – spouse catch-up contributions must be made into their own personally established HSA, not the HSA of the employee.*
- *All contribution limits include both employee payroll and employer contributions.*

City of Grapevine and employee contributed HSA funds are added to individual accounts bi-annually. Total employer and employee contribution amounts are divided in half and uploaded in October and April in lump sums. HSA Bank provides tax forms at the end of the year to file with your personal taxes. All medical expense receipts need to be retained by you to document eligible distributions.

THINGS TO REMEMBER

- *HSA contributions are not available to those individuals enrolled in Medicare or employees who are enrolled in any other non-HSA qualified health insurance plan (VA benefits excluded).*
- *HSA distributions are tax-free for qualified expenses if taken by you, your spouse or dependent(s). Your spouse and dependents do not need to be covered by a high deductible health plan.*
- *An employee will lose HSA eligibility if a spouse elects to participate in a general FSA and can use the FSA money to pay for that employee's general health expenses, regardless of whether or not the spouse actually does use the FSA for the employee's health expenses.*
- *Elect an HSA beneficiary online or by contacting HSA Bank.*

HSA Bank | 800.357.6246 | hsabank.com

HEALTH REIMBURSEMENT ACCOUNT (HRA)

A Health Reimbursement Account (HRA) is an arrangement that is funded by the City of Grapevine. This account will only reimburse qualified medical (Rx excluded) care expenses eligible for coverage under your medical benefit plan. Your HRA is financed with an employer contribution as shown on the schedule of benefits for the 12-month benefit plan year.

The Health Reimbursement Account is managed by UMR. All claims are paid directly from UMR, once the employee threshold deductible is met for the plan year, the HRA will automatically be accessed by UMR. The HRA will continue to pay until the account is depleted. This is an employee hands-off account, so no action is necessary on your part to use these funds. These funds will not rollover each plan year. Any funds remaining at the end of the plan year will be forfeited back to the City.

UMR | 877.360.4503 | umr.com

PHARMACY AND SPECIALIZED PROGRAMS

PRESCRIPTION DRUG PLAN

UMR's medical plans include coverage for prescription drugs. You may fill your prescriptions at participating retail pharmacies or through the mail order service. The Traditional plan includes coverage for prescription drugs and those costs go towards the prescription drugs out-of-pocket maximum.
All prescriptions on the Premier plan will not have a prescription co-pay until after the plan deductible is met.

RETAIL PHARMACY

When you present your medical plan ID card at a participating pharmacy, your specific plan prescription benefits will be applied. Keep in mind that generic drugs cost significantly less than their brand name counterparts, yet they can be equally effective. If you request a brand name drug when a generic is available, you will be required to pay the difference between the cost of the generic and the formulary/nonformulary brand name drug plus the applicable co-payment.

MAIL ORDER

If you are taking a maintenance medication such as high blood pressure, asthma, or diabetes medication, as well as birth control pills, you will save money and save time if you utilize the mail-order service offered through Optum Rx.

Optum Rx | 877.559.2955 | optumrx.com

NURSE LINE

Provides round-the-clock telephone access to registered nurses who can offer assistance and answer questions on a variety of health topics. Call 1-877.950.5083, Pin 197.

HEALTHY BACK

Healthy Back is a personalized support program that integrates both clinical and lifestyle coaching, using both nurses and chiropractors, to reach members with recurring lower back pain. By partnering with coaches through OptumRx, you will have improved health results and reduced pain, while also reducing medical spend through decreased surgery and the use of specialists.

Opportunities for enrollment are identified through medical and/or pharmacy claims data. If you are considered eligible for the healthy back program, OptumRx will send an invitation letter.

PREVENTATIVE CARE

Preventative care is very important for adults and children. By making smart health choices, women and men can boost their own health and well being.

Below is a list of services covered at no cost to the employee and any covered dependents if the member visits an in-network provider:

- An annual checkup
- Age and gender specific health screenings, including cholesterol, blood pressure, blood sugar and weight
- Routine immunizations based on your age, stage of life and health status including the annual flu shot

MATERNITY MANAGEMENT

Maternity Management helps expectant mothers understand and manage pregnancy. The program supports mothers through pregnancy: Pregnancy risk factor identification, educational materials, personal telephone contact, and assistance in managing high risk conditions.

As part of the free program, City of Grapevine is offering a reward covering in-network services at 100% if enrolled in the first trimester and a $25 reward card for signing up in the first or second trimester.

Visit the health center on www.umr.com or call 888.438.8105 to enroll.

FAMILY CLINICS

CITY OF GRAPEVINE EMPLOYEE AND FAMILY CLINIC PROGRAM

- Clinic ID card must be presented at the time of service
- All active City employees and their dependents are eligible to use the program
  - An eligible dependent is defined as a spouse and/or dependent children under the age of 26
- Walk-in for a same day office visit; call ahead for same day appointment, if possible
- **No copay for clinic visits**
- Acute care includes coughs, colds, flu, sinus infections, sore throats, ear aches, and other minor illnesses
- Providers are in the United Healthcare Choice Plus network, so you can also be treated for other medical conditions at a separate visit if you are on the City medical plan. Regular plan benefits will apply.

Texas Health Family Care
2000 Emery Street
Denton, Texas 76201
(940) 484-4424

Texas Health Family Care
4001 Long Prairie Road, #125
Flower Mound, Texas 75028
(972) 539-3030

Texas Health Internal Medicine
1924 Forest Ridge Drive, B
Bedford, Texas 76021
(817) 354-2680

Texas Health Family Care
1600 W Northwest Highway, #100
Grapevine, Texas 76051
(817) 912-0442

Texas Health Family Care
1280 S Main Street #100
Grapevine, Texas 76051
(817) 310-0898

Texas Health Family Care
100 Bourland Road, #100
Keller, Texas 76248
(817) 379-5100

IMPORTANT : Do not see the doctors above for worker's compensation injuries.

DENTAL PLAN

Dental coverage is an important component of the City of Grapevine's comprehensive benefit plan. Coverage is offered through Cigna. Participants have access to a Total Cigna DPPO network. Out-of-network provider costs will be reimbursed based on reasonable and customary fees. This reimbursement may not cover the full cost of services. In these cases, you may be balance-billed for the amount exceeding the reimbursement.

DENTAL PROVISIONS		IN-NETWORK	NON-NETWORK
ANNUAL DEDUCTIBLE	Individual	$0	$50
	Family	$0	$150
MAXIMUMS	Class I, II, III Combined Fiscal Year Maximum Benefit	$2,000	$2,000
	Class IV: Lifetime Maximum	$2,500	$2,500
SERVICES	Class 1: Preventative Services Oral Exams, X-Rays, Bitewing X-Rays, Sealants, Prophylaxis/Cleanings, Topical Flouride Application, Space Maintainers	100%	100%
	Class 2: Basic Services Fillings, Extractions, Basic Oral Surgery, Anestesia, Endodontic, Root Canal Therapy, Periodontics, Crowns	90%	80%
	Class 3: Major Services Bridges, Dentures, Implants	60%	50%
	Class 4: Orthodontia	50%	50%

	DENTAL	
	Monthly	Bi-weekly
PREMIUMS Employee Only	$0	$0
Employee And Spouse	$15.00	$6.92
Employee And Children	$15.00	$6.92
Employee And Family	$20.00	$9.23

CIGNA | 800.244.6224 | mycigna.com

VISION PLAN

Vision coverage is provided through Vision Service Plan (VSP). VSP provides an extensive network of vision optometrists and ophthalmologists. Eye care is essential to a person's health and well-being. Members receive benefits on many eye care services and products including eye exams, eyeglasses, and contact lenses.

		IN-NETWORK	NON-NETWORK
STANDARD EYE EXAM		100%	Up to $45
MATERIALS	Single Vision Lenses	100%	Up to $30
	Bifocal Lenses	100%	Up to $50
	Trifocal Lenses	100%	Up to $65
FRAMES		$150 Retail Allowance + 20% off balance	Up to $70
CONTACTS (instead of frames)		100% to $135 allowance	Up to $105

		VISION	
		Monthly	Bi-weekly
PREMIUMS	Employee Only	$0	$0
	Employee And Spouse	$10.00	$4.62
	Employee And Children	$10.00	$4.622
	Employee And Family	$15.00	$6.92

NO ID CARD NECESSARY
Employees use their social security number and date of birth when utilizing benefits.

VSP | 800.877.7195 | vsp.com

EAP AND COMPASS HEALTH SERVICES

EMPLOYEE ASSISTANCE PROGRAM (EAP)

City of Grapevine has partnered with Deer Oaks to provide an Employee Assistance Program (EAP) at no cost to you and your dependents.

The EAP provides up to eight (8) free counseling sessions per incident. The EAP is designed to assist with a wide array of issues, including:

> Work/Life Services
- Concierge
  - Child & Elder Care
  - Home Repair & Cleaning
  - Pet Training & Boarding
  - Tutors
  - Travel Planning
  - Volunteer Opportunities
- Referrals
- Consultations

> Stress, Anxiety, & Depression

> Legal Assistance
- Free 30 Minute Consultation (phone/in-person)
- 25% Discount on Hourly Attorney Fees
- Free Will Preparation

> Financial Assistance
- Unlimited Phone Services
- Accredited Financial Counselor

> ID Theft Prevention & Recovery

> Take the High Road Program
- Cab, Uber, Lyft Reimbursement
- Once per person/per year
- $45.00 reimbursement

The free confidential service is available to you and your family members - 24 hours a day, seven days a week.

Deer Oaks | 866.327.2400 | deeroakseap.com
Login: grapevine | Password: grapevine

COMPASS PROFESSIONAL HEALTH SERVICES

Compass is a patient advocate and concierge service, contact them for any of the following:

- Pricing estimates for health procedures
- Doctor recommendation
- Assistance with reviewing your EOB's
- Questions on your health insurance and more
- Mobile app available!

Navigate the complex healthcare system and receive answers to questions 24/7 – everything you need to make smart healthcare decisions. Get personal guidance and connect with your Health Pro today!

800.513.1667 | compassphs.com/getconnected

FLEXIBLE SPENDING AND DEPENDENT CARE ACCOUNTS

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

You may set aside, for yourself and your tax dependents, pre-tax dollars each year for eligible health care expenses. Contributions are deducted from your paycheck in equal amounts during the year but you have access to the entire election amount at the start of the plan year. You are not elegible for a health care flexible spending account if enrolled in the Premier health plan. *Annual contribution limit: $2,650*

LIMITED PURPOSE FLEXIBLE SPENDING ACCOUNT

You are eligible for this account if you enroll in the Premier health plan and participate in a Health Savings Account (HSA). It allows you to set aside additional money pre-tax for certain dental and vision expenses.
Annual contribution limit: $2,650

DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT

Pre-tax dollars may be used for day care or elder expenses for eligible dependents allowing you (or your spouse, if married) to work, look for work or attend school full-time. Contributions are deducted from your paycheck in equal amounts during the year.
Annual contribution limit: $5,000

FILING A CLAIM

TASC Benefits Card

The amount is deducted from your account balance. All enrolled members will receive a TASC card in the mail.

OR

Request a Reimbursement

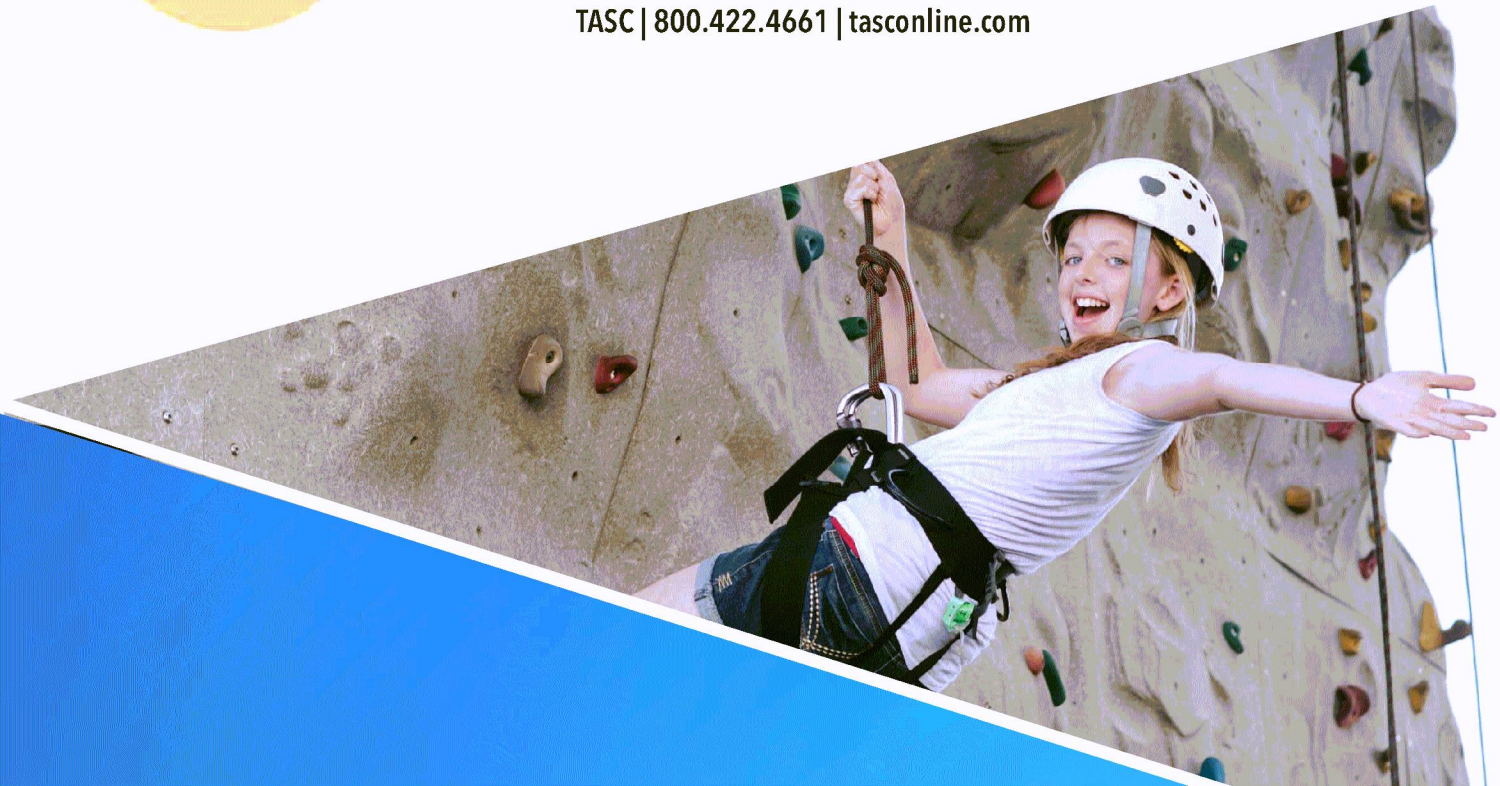
Submit a request using one of the following methods:
- *Submit via MyTASC Mobile App (free download)*
- *Submit via MyTASC Text Message (SMS)*
- *Download Request for Reimbursement form online (Paper)*

ALL reimbursements are direct deposited into your MyCash account OR a designated bank account. MyCash funds are accessible via your TASC card to be used for any type of purchase or ATM withdrawal.

IMPORTANT PROGRAM INFORMATION

Expense Deadline: *For fiscal year 2019, you must incur all eligible expenses by December 15, 2019*
Claims Deadline: *For fiscal year 2019, you must submit all reimbursement requests by December 31, 2019.*
Enrollment: *You must re-enroll each year to continue participation. Elections do not carry forward from year to year.*
Carryover: *Unused funds do not rollover into the next plan year.*

TASC | 800.422.4661 | tasconline.com



BASIC LIFE AND DISABILITY

BASIC LIFE AND AD&D COVERAGE

City of Grapevine provides all full-time and regular part-time employees with a Basic Life and AD&D benefit. The benefit is 100 percent employer paid. Eligible employees are covered at two times their annual base salary with a maximum of $350,000. If you suffer a covered loss due to an accident, AD&D coverage pays you a portion of the full benefit.

City of Grapevine provides all elected officials with a Basic Life and AD&D benefit. The benefit is 100 percent employer paid. The elected officials have a $50,000 policy.

Coverage amounts automatically reduce at ages 65, 70 and 75. Upon your attainment of the specified age below, the amount of Basic Life Insurance will be reduced to the applicable percentage.

65-69 years old	65% of available or in-force amount
70 years old	50% of available or in-force amount
75 years old	35% of available or in-force amount

VOLUNTARY GROUP LIFE COVERAGE

If you need additional life insurance, you may purchase Voluntary Life and AD&D coverage for yourself and your eligible dependents. You may elect coverage for yourself and your spouse in $10,000 increments. You may also elect coverage for your child(ren) up to the amount of $15,000. The child(ren) coverage does not include an AD&D policy.

As long as you elect at least $10,000 in coverage on yourself during the initial enrollment period, you are eligible to increase up to the guarantee issued amount at any time without having to complete additional paperwork.

All voluntary life insurance rates can be found by logging into SmartBen.

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	EMPLOYEE	SPOUSE	CHILD
Minimum	$10,000	$10,000	$2,000
Maximum	$500,000	$250,000	$15,000
Guarantee Issue	$200,000	$50,000	$15,000 (6 months to 26 years)

SHORT-TERM AND LONG-TERM DISABILITY

Disability insurance provides protection in the event you experience a non-work related injury or illness that prevents you from working. The City of Grapevine pays for the Long-Term Disability coverage and the Short-Term Disability coverage can be voluntarily elected and paid for through payroll deductions. Both plans are administered by Unum.

SHORT-TERM DISABILITY (STD)

Your benefits will begin on the eighth day following a nonoccupational accidental injury, sickness, or pregnancy. STD pays 60 percent of basic weekly predisability earnings (not including overtime, bonuses, and other extra compensation) up to a maximum of $1,000 a week, less deductible sources of income. Deductible sources of income do not include vacation or sick time. The maximum benefit duration is 11 weeks. Evidence of Insurability (EOI) is required to add benefit if you are not enrolling as a new hire or coverage was not previously elected.

LONG-TERM DISABILITY (LTD)

In the event your disability continues after STD ends, then LTD is available. LTD benefits will be 60 percent of predisability earnings (not including overtime, bonuses, and other extra compensation) up to a maximum of $5,000 per month, less deductible sources of income. Deductible sources of income do not include vacation time. Benefits can last up to social security normal retirement age.

CRITICAL ILLNESS INSURANCE

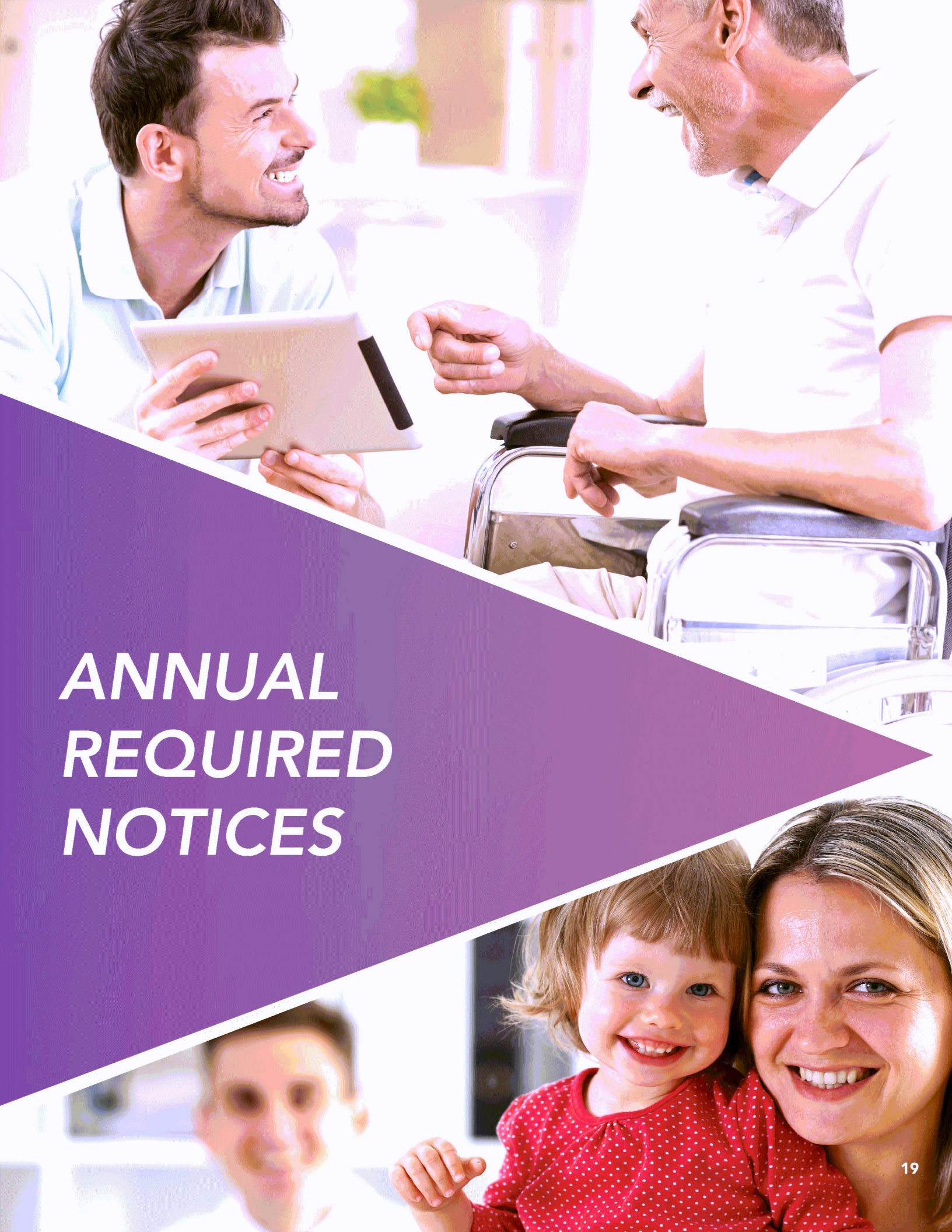
- Critical illness insurance is a limited benefit policy that pays a one-time, lump sum benefit amount upon the diagnosis of a covered disease or illness. You are eligible to purchase up to $20,000 in coverage
- Critical illness insurance is not considered health insurance and will not satisfy the requirement of minimum essential coverage under the Affordable Care Act
- Coverage is available without a medical questionnaire
- Dependent coverage is also available and the coverage is portable
- Any claims (including wellness rider claims) must fall within the current benefit plan year
- Examples of covered care:
  - Heart attack
  - Stroke
  - Coma
  - Major organ failure
  - Cancer; Skin Cancer – 10% of Maximum Benefit elected

**All critical illness insurance rates and a schedule of benefits can be found by logging into SmartBen*

ACCIDENT INSURANCE

- Accident insurance is a limited benefit policy that pays a specified amount for specific injuries resulting from a covered accident
- Accident coverage is not considered health insurance and will not satisfy the requirement of minimum essential coverage under the Affordable Care Act
- Coverage is available without a medical questionnaire
- Dependent coverage is also available and the coverage is portable
- Any claims (including wellness rider claims) must fall within the current benefit plan year
- Examples of covered care:
  - Accident hospital care
  - Follow-up care
  - Emergency care
  - Fractures, dislocations, and other common injuries

**All accident insurance rates and a schedule of benefits can be found by logging into SmartBen*



ANNUAL REQUIRED NOTICES

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 23, 2013 and shall remain in effect until you are notified of any changes, modifications or amendments. This Notice applies to health information the following plan[s] (referred to herein as the "Plan") create[s] or receive[s] about you:

CITY OF GRAPEVINE EMPLOYEE HEALTH BENEFIT PLAN

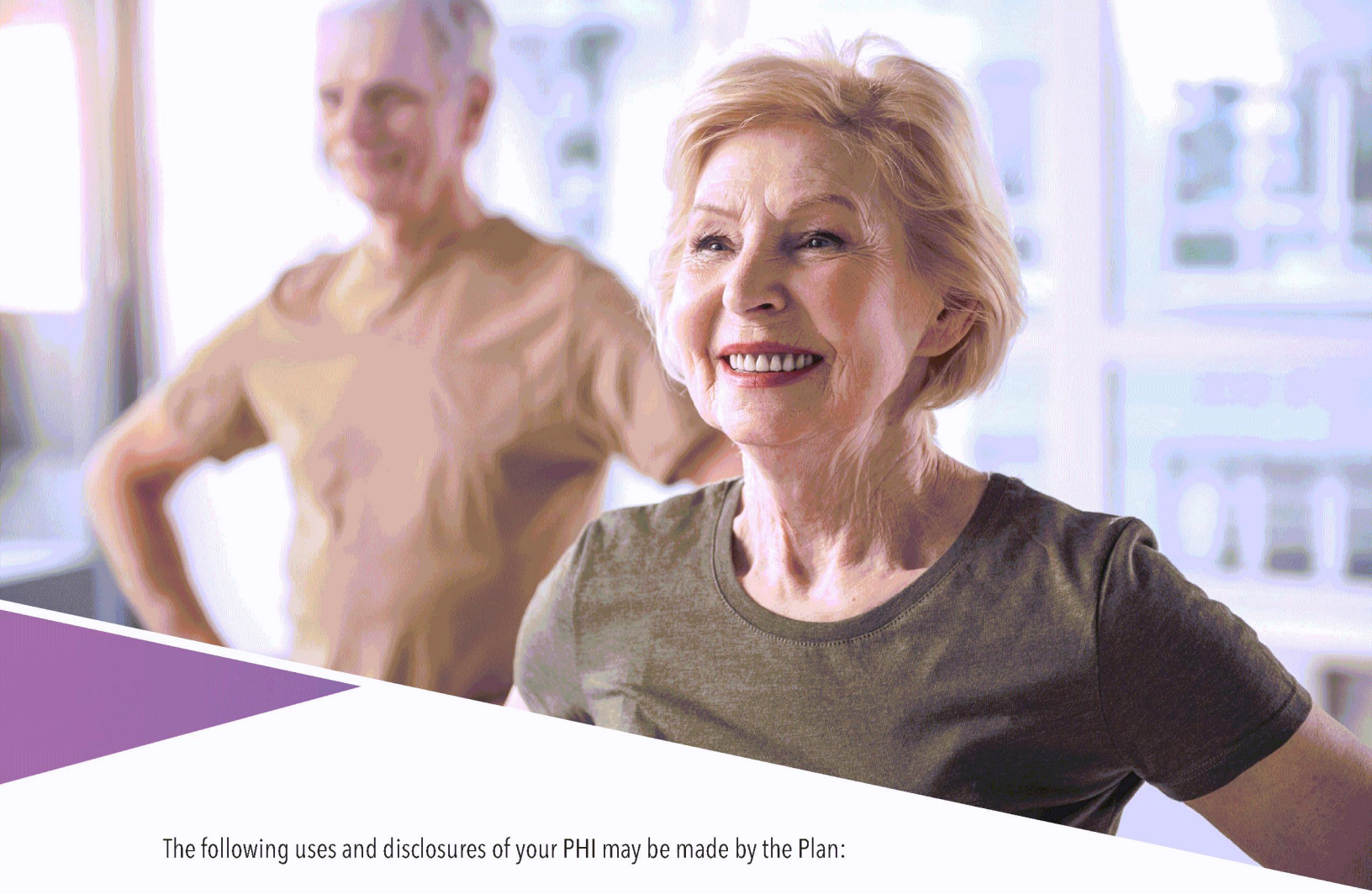
You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), mandated the issuance of regulations to protect the privacy of individually identifiable health information, which were issued at 45 CFR Parts 160 through164 (the "Privacy Regulations"). Since their initial publication, the Privacy Regulations were amended by the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA"), and by modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, as published in the Federal Register on January 25, 2013. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information, including"genetic information" (as defined in Section 105 of GINA), that is created or received by the Plan (your "Protected Health Information" or "PHI'). This Notice is intended to inform you about how the Plan will use or disclose your PHI, your privacy rights with respect to the PHI, the Plan's duties with respect to your PHI, your right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services ("HHS") and the office to contact for further information about the Plan's privacy practices.

HOW THE PLAN WILL USE OR DISCLOSE YOUR PHI

Other than the uses or disclosures discussed below, any use or disclosure of your PHI will be made only with your written authorization. Any authorization by you must be in writing. You will receive a copy of any authorization you sign. You may revoke your authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. Your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself provides such right.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. Effective for uses and disclosures on or after February 17, 2010 until the date the Secretary of HHS issues guidance on what constitutes the "minimum necessary" for purposes of the privacy requirements, the Plan shall limit the use, disclosure or request of PHI (1) to the extent practicable, to the limited data set or (2) if needed by such entity, to the minimum necessary to accomplish the intended purpose of such use, disclosure or request. The minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- uses and disclosures made pursuant to a valid authorization



The following uses and disclosures of your PHI may be made by the Plan:

For Payment. Your PHI may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the Plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your PHI may be disclosed to other health plans maintained by the Plan sponsor for any of the purposes described above. Uses and disclosures of PHI for payment purposes are limited by the minimum necessary standard.

For Treatment. Your PHI may be used or disclosed by the Plan for purposes of treating you. One example would be if your doctor requests information on what other drugs you are currently receiving during the course of treating you.

For the Plan's Operations. Your PHI may be used as part of the Plan's health care operations. Health care operations include quality assurance, underwriting and premium rating to obtain renewal coverage, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and quality improvement activities, and customer service and resolution of internal grievances. The Plan is prohibited from using or disclosing your PHI that is genetic information for underwriting purposes. Uses and disclosures of PHI for health care operations are limited by the minimum necessary standard.

NOTICE OF PRIVACY PRACTICES

The following use and disclosure of your PHI may only be made by the Plan with your written authorization or by providing you with an opportunity to agree or object to the disclosure:

To Individuals Involved in Your Care. The Plan is permitted to disclose your PHI to your family members, other relatives and your close personal friends involved in your health care or the payment for your health care if:

- the PHI is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected; and
- the PHI is needed for notification purposes, or, if you are deceased, the PHI is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

The following uses and disclosures of your PHI may be made by the Plan without your authorization or without providing you with an opportunity to agree or object to the disclosure:

For Appointment Reminders. Your PHI may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. PHI may be provided to the sponsor of the Plan provided that the sponsor has certified that this PHI will not be used for any other benefits, employee benefit plans or employment-related activities.

When Required by Law. The Plan may also be required to use or disclose your PHI as required by law. For example, the law may require reporting of certain types of wounds or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena received by the Plan.

For Workers' Compensation. The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illnesses without regard to fault.

For Public Health Activities. When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Your PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

To Report Abuse, Neglect or Domestic Violence. When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, the Plan is not required to inform the minor that such a disclosure has been or will be made.Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's PHI.

For School Records. The Plan may disclose immunization records for a student or prospective student to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.

For Public Health Oversight Activities. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

For Judicial or Administrative Proceedings. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, the notice provided sufficient information about the proceeding to permit you to raise an objection, and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

For Other Law Enforcement Purposes. The Plan may disclose your PHI for other law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

To a Coroner or Medical Examiner. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors,consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

For Research. The Plan may use or disclose PHI for research, subject to certain conditions.

To Prevent or Lessen a Serious and Imminent Threat. When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

State Privacy Laws. Some of the uses or disclosures described in this Notice may be prohibited or materially limited by other applicable state laws to the extent such laws are more stringent than the Privacy Regulations. The Plan shall comply with any applicable state laws that are more stringent when using or disclosing your PHI for any purposes described by this Notice.

YOUR PRIVACY RIGHTS WITH RESPECT TO PHI

Right to Request Restrictions on PHI Uses and Disclosures. You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI.

Right to Inspect and Copy PHI. You have a right to inspect and obtain a copy of your PHI contained in a "designated record set", for as long as the Plan maintains the PHI, other than psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or PHI that is maintained by a covered entity that is a clinical laboratory. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment. To the extent that the Plan uses or maintains an electronic health record, you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person.

A "designated record set'' includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a statement of your reviewrights, a description of how you may exercise those review rights and a description of how you may complain to HHS.

Right to Amend. You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

You must make requests for amendments in writing and provide a reason to support your requested amendment.

Right to Receive an Accounting of PHI Disclosures. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting. Notwithstanding the foregoing, if your Plan maintained electronic PHI as of January 1, 2009, effective January 1, 2013, you can request an accounting of all disclosures by the Plan of your electronic PHI during the three years prior to the date of your request.

Right to Receive Confidential Communications. You have the right to request to receive confidential communications of your PHI. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you.

Right to Receive a Paper Copy of This Notice Upon Request. To obtain a paper copy of this Notice, contact the Privacy Official at the address and telephone number set forth in the Contact Information section below.

A Note About Personal Representatives. You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a court order of appointment of the person as the conservator or guardian of the individual;
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

THE PLAN'S DUTIES WITH RESPECT TO YOUR PHI

The Plan is required by law to maintain the privacy of PHI and provide individuals with notice of its legal duties and privacy practices with respect to the PHI.

The Plan is required to abide by the terms of the notice that are currently in effect.

The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this Notice and to apply such changes to all PHI the Plan maintains. Any PHI that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all PHI it receives or maintains. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice.

The Plan is required to notify you of any "breach" (as defined in 45 CFR 164.402 of the Privacy Regulations) of your unsecured PHI.

CONTACT INFORMATION

COVERAGE/CARRIER	PHONE NUMBER	WEBSITE
Cigna (Dental)	800.244.6224	mycigna.com *(mobile app available)*
Compass (Patient Advocate Service)	800.513.1667	compassphs.com/getconnected *(mobile app available)*
HSA Bank (Health Savings Account)	800.357.6246	hsabank.com *(mobile app available)*
Deer Oaks (Employee Assistance Program)	866.327.2400	deeroakseap.com *(mobile app available – iConnectYou)*
Optum Rx (Prescription)	877.559.2955	optumrx.com *(mobile app available)*
TASC (FSA, DCA)	800.422.4661	www.TASConline.com *(mobile app available)*
UMR (Medical)	877.360.4503	umr.com *(mobile website available)*
Unum (Life, AD&D, Disability)	800.421.0344	unum.com *(mobile app available)*
Vision Service Plan (Vision)	800.877.7195	vsp.com *(mobile app available)*
SimplyWell (Wellness Program)	888.848.3723	connect.simplywell.com *(mobile app available)*
Voya (Accident & Critical Illness)	877.236.7564	voya.com *(mobile app available)*

The descriptions of the benefits are not guarantees of current or future employment or benefits. If there is any conflict between this guide and the official plan documents, the official documents will govern.

GRAPEVINE
TEXAS
RISK MANAGEMENT

200 South Main Street
Grapevine, TX 76051
817.410.3119
grapevinetexas.gov